NURSING FACILITY

PRICE-BASED PAYMENT METHODOLOGY FAQs

(Revised November 19, 2014)

Note: *Highlighted questions indicate revisions to Q&A or a new question since the last FAQ posting on November 4, 2014.*

PRICE-BASED PAYMENT IMPLEMENTATION AND REIMBURSMENT

Q1. What is the timeframe for DMAS to implement a new price-based payment methodology?

Q2. How will the rates under the new price-based payment methodology differ from the current cost-based system?

Q3. How was the nursing facility price-based payment model developed?

Q4. What are the peer groups for the price-based payment methodology?

Q5. What are price-based spending floors?

Q6. Will there be a transition to the new price-based payment system?

Q7. Is a State Plan Amendment (SPA) required for the change in reimbursement methodology to a price-based payment system?

FRV RENTAL RATE

Q8. How will the price-based payment methodology impact FRV rates?

Q9. Why are the Fair Rental Value (FRV) rates (effective July 1, 2014) that were pending budget approval different than the rates posted on the DMAS website?

Q10. Does the Fair Rental Value (FRV) rate remain at 8% for FYs 15 and 16?

Q11. Since DMAS will make a mid-year FRV rate adjustment for new beds or a major renovation ($3,000 per bed), is the old FRV capital rule of $50,000 per project no longer valid?

Q12. Will the RS Means by location and Average Age Calculation remain the same under the new price-based methodology?

Q13. If a facility adds additional beds, will inflation be added to the 2011 cost report period, or will the rebasing period be updated plus inflation?

RUG BILLING REQUIREMENTS/POLICIES AND MDS ASSESSMENTS

Q14. Will the new price-based methodology affect billing procedures for nursing facility providers?

Q15. What is the billing period for nursing facility providers?

Q16. Where are the RUG weights located?

Q17. How will the RUG weights impact reimbursement?

Q18. What RUG score will be used for the rates effective July 1st and November 1st?

Q19. What RUGS grouper will DMAS use for case mix purposes?

Q20. What case mix scores will be used to calculate the November 1, 2014 rates that will be paid on a claim-by-claim basis?

Q21. What MDS assessment and RUG code should be billed at the start of an admission?

Q22. How should the RUG score be submitted on the claim?

Q23. Since MDS assessments are currently done every 92 days, is that what will be used for billing?

Q24. Effective November 1, 2014, how often will the Case Mix Index (CMI) score for each patient need to be updated for billing purposes?

Q25. What version of the RUGs Grouper is being used for price-based reimbursement?

Q26. How does DMAS define a late assessment?

Q27. What types of assessments in A0310 may be used for payment?

Q28. Where should the assessment reference date be reported on the claims?

Q29. If a member exhausts Medicare benefits and Medicaid becomes the primary payer, which MDS should be used to bill the initial RUG under Medicaid?

Q30. What amount will DMAS pay if the calculated PB reimbursement is greater than actual charges?

Q31. What is the procedure for adjusting claims for RUG billing?

Q32. If an OBRA is combined with a PPS MDS, will the facility use the A0310A for the assessment type/modifier for billing even though the MDS is combined?

Q33. a.) If a resident discharges from the facility prior to the due date of his quarterly assessment and returns after the quarterly assessment was due, how can the facility prevent receiving the default RUG payment? b.) Since facility's do not bill for days in the facility, would an ARD need to be set upon returning to the facility to prevent default RUG payment or combine the quarterly due with the discharge?

Q34. What two digits should be used following the RUG code?

COST SETTLEMENT AND REPORTING

Q35. How much of the current payment (effective July 1, 2014) will be cost settled?

Q36. Will changes be made to the existing PIRS cost report to report Medicaid Coordinated Care days separately on Schedules H and R-1?

INTERMEDIATE CARE FACILITES (ICFs) OPERATED BY DBHDS

Q37. How will the new price-based reimbursement methodology affect payments to Intermediate Care Facilities (ICFs)?

HOSPICE REIMBURSEMENT

Q38. How will the price-based methodology impact reimbursement for hospice services when using a nursing facility?

NEW NURSING FACILITIES

Q39. How will the rate for a new nursing facility be established under price-based reimbursement?

THERAPEUTIC LEAVE

Q40. If a resident's ARD becomes due before the resident returns to the facility will the nursing facility have to bill the default RUG code? Could the nursing facility set the ARD early before the resident leaves for therapeutic leave?

Q41. How should facilities bill the RUG units for claims with therapeutic leave?

GENERAL QUESTIONS

Q42. Will rates be updated annually?

Q43. Will there be any additional state funding for Medicaid rates?

Q44. How can I contact DMAS if I have additional questions regarding changes to the nursing facility payment methodology, including changes to FRV?

PRICE-BASED PAYMENT IMPLEMENTATION AND REIMBURSMENT

Q1. What is the timeframe for DMAS to implement a new price-based payment methodology?

A1. **On January 9, 2014, the DMAS Nursing Facility Medicaid Payment Workgroup unanimously voted in favor of implementing a fully prospective price-based payment methodology starting July 1, 2014. The DMAS workgroup is comprised of representatives of all three associations representing nursing facilities– VHCA, VHHA and VANHA. The 2014 General Assembly will consider a budget amendment to implement the new methodology.**

Q2. How will the rates under the new price-based payment methodology differ from the current cost-based system?

A2. **The proposed Nursing Facility Price-Based Payment Methodology includes the following:**

- **Fully prospective operating rates for direct and indirect costs**
- **Based on costs from a base year inflated to the rate year**
- **Adjusted for regional cost differences**
- **Direct costs are "neutralized" using raw case mix rather than normalized case mix**
- **The rate for direct costs is based on an adjustment factor of 105% of the Medicaid day-weighted median for freestanding nursing facilities by peer group and the rate for indirect costs is based on an adjustment factor of 100.7% of the Medicaid day-weighted median for indirect costs for freestanding nursing facilities by peer group**
- **There will be a price-based spending floor**
- **The direct rate component will be adjusted on each claim by the resident's current Medicaid RUGs score (similar to the determination of Medicare rates)**
- **The final rate will add prospective payment for capital , NATCEPs (nurse aide training), and criminal records checks**

Q3. How was the nursing facility price-based payment model developed?

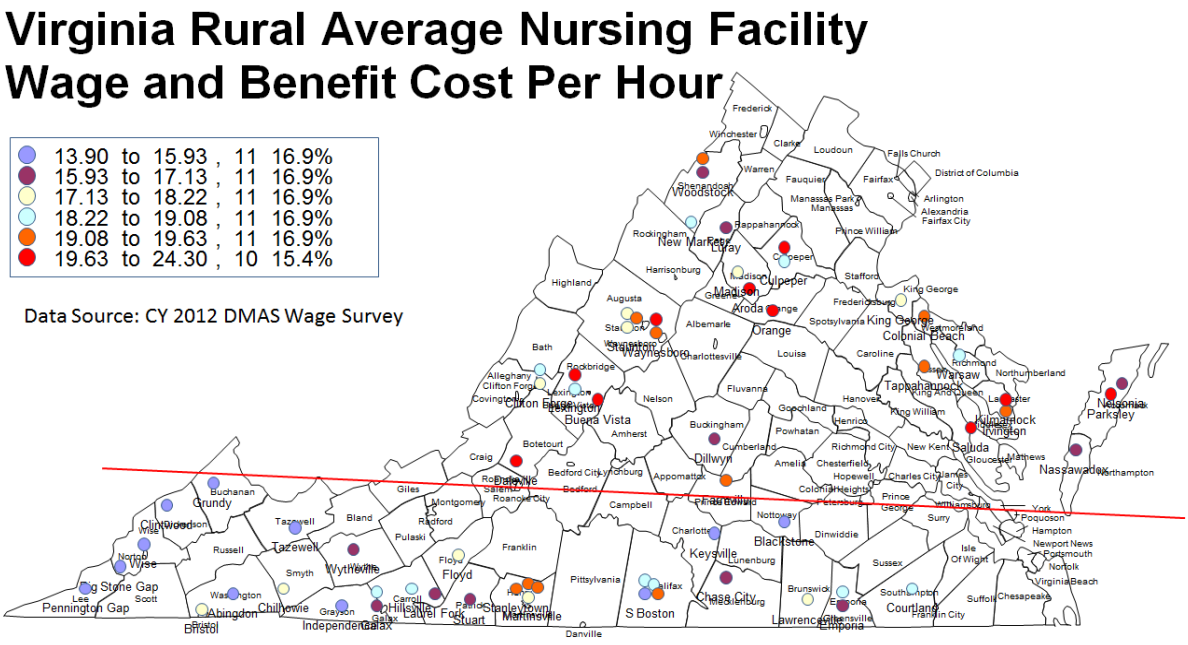
A3. **The price-based payment model was developed using the 2011 NHDB direct and indirect operating costs per day. Direct costs were neutralized by raw facility case mix and inflated to SFY15. An adjustment factor was calculated as a percentage of Medicaid day-weighted median of free-standing nursing facilities by peer group to determine price.**

Q4. What are the peer groups for the price-based payment methodology?

A4. **The peer groups for price-based payment calculations are a combination of Medicare wage regions and Medicaid rural and bed size classifications based on similar costs.**

Direct Peer Groups	Indirect Peer Groups
• Northern Virginia MSA	• Northern Virginia MSA
• Other MSAs	• Rest of State – Greater than 60 Beds
• Northern Rural	• Other MSA
• Southern Rural	• Northern Rural
	• Southern Rural
	• Rest of State – 60 Beds or Less

See attached map that shows Northern Rural and Southern Rural.



Q5. What are price-based spending floors?

A5. **All facilities receive full price if costs, inflated to SFY 2015 are at or above 95% of the price. Facilities with projected costs below 95% of the price have an adjusted price equal to the price minus the difference between their projected cost and 95% of the unadjusted price. By limiting the potential gain of low cost facilities, it is possible to implement higher adjustment factors for other facilities at a lower overall expenditure level and reduce the amount of transition losses for higher cost facilities.**

Q6. Will there be a transition to the new price-based payment system?

A6. **There will be a four year transition. Rates will be a blend of the facility's current cost-based rate and new price-based rate in 25-percent increments. The cost-based rate component will be prospectively established based on the current cost-based methodology with PFY11 cost report inflated to the rate period. Current cost-based rates include a facility case mix adjustment for the direct cost component. DMAS will remove the case mix adjustment from the direct cost component of the cost-based rate because the case mix adjustment will be determined on an individual claim basis.**

During the first transition year for the period July 1, 2014 through October 31, 2014, DMAS shall case mix adjust each direct cost component of the rates using the average facility case mix from the two most recent finalized quarters (September and December 2013) instead of adjusting this component claim by claim.

Q7. Is a State Plan Amendment (SPA) required for the change in reimbursement methodology to a Price-Based Payment System?

A7. **Based on the authority granted by Item 301.KKK of the 2014 Appropriation Act, DMAS will submit a State Plan Amendment (SPA) for the price-based methodology.**

FRV RENTAL RATE

Q8. How will the price-based payment methodology impact FRV rates?

A8. **DMAS will continue to reimburse freestanding nursing facilities for its capital costs through FRV. In order to make FRV prospective with the state fiscal year, providers will be required to submit calendar year FRV reports. FRV rates for the upcoming fiscal year will be based on the prior calendar year information aged to the state fiscal year and using RS Means factors and rental rates corresponding to the fiscal year. DMAS will make mid-year FRV rate adjustment for new beds or a major renovation.**

Q9. Why are the Fair Rental Value (FRV) rates (effective July 1, 2014) that were pending budget approval different than the rates posted on the DMAS website?

A9. **The FRV rates posted on the DMAS website reflect the 8.0 percent rental rate mandated in Item 301.KKK of the Act. Myers and Stauffer will be sending a revised FRV rate letter to all nursing facility providers.**

Q10. Does the Fair Rental Value (FRV) rate remain at 8% for FYs 15 and 16?

A10. **Yes, the rental rate floor will remain at 8% based on the SFY 2015 approved budget.**

Q11. Since DMAS will make a mid-year FRV rate adjustment for new beds or a major renovation ($3,000 per bed), is the old FRV capital rule of $50,000 per project no longer valid?

A11. **The Schedule of Assets grouping of $50,000 per project is still valid. The Schedule of Assets Reporting should not be confused with the $3,000 per bed threshold for major renovations. The regulations in 12VAC30-90-38, subsection D will remain in effect.**

Q12. Will the RS Means by location and Average Age Calculation remain the same under the new price-based methodology?

A12. **Yes, the RS Means by location and Average Age Calculation will remain the same.**

Q13. If a facility adds additional beds, will inflation be added to the 2011 cost report period, or will the rebasing period be updated plus inflation?

A13. **The operating rate will not change based on a change in the FRV rate and/or the number of beds.**

RUG BILLING REQUIREMENTS/POLICIES AND MDS ASSESSEMENTS

Q14. Will the new price-based methodology affect billing procedures for nursing facility providers?

A14. **The transition to price-based reimbursement will not affect billing effective July 1, 2014. However, nursing facilities will be required to submit RUG codes similar to the Medicare billing policy effective November 1, 2014. DMAS issued a Medicaid Memo on June 25, 2014 and the billing procedure Medicaid Memo on September 26, 2014.**

Q15. What is the billing period for nursing facility providers?

A15. **Currently providers may bill weekly or monthly. The RUG code billed must match the RUG code documented on the MDS assessment that applies to the dates of service submitted on the claim. Monthly billers may choose to report multiple RUG codes on individual revenue lines on the same claim. (*Revised from 9/26 Medicaid Memo*)**

Q16. Where are the RUG weights located?

A16. **The RUG weights are listed on the DMAS website at the following link http://www.dmas.virginia.gov/Content_pgs/pr-rsetting.aspx under Nursing Facilities, Resource Utilization Group (RUG) Weights**

Q17. How will the RUG weights impact reimbursement?

A17. **Each resident will be reimbursed based on their current RUG weight.**

Q18. What RUG score will be used for the rates effective July 1st and November 1st?

A18. **For the July 1st rates, the case-mix adjustment reflects the facility-average for the two most recent quarters. Effective November 1, the billing instructions published in the Medicaid Memo will describe the method to bill the Medicaid (RUG-III, version 34) RUG assessment code determined by the MDS assessment for each resident during the billing period. The RUG code submitted for the billing period will be mapped to the RUG weight (CMI score). The billing method will be very similar to the Medicare billing method.**

The RUG score should reflect the RUG code applicable to the dates of service in the billing period as calculated on the MDS assessment. DMAS will publish the RUG weight file when the Medicaid Memo is sent.

Q19. What RUGS grouper will DMAS use for case mix purposes?

A19. **Initially, DMAS will continue to use the RUGS III – 34 Medicaid grouper and associated weights. DMAS with input from the nursing facility workgroup will consider implementing RUGs IV-48 Medicaid Grouper and associated weights in year two of the four-year phase-in period. RUGs IV - 48 is a more refined grouper with updated weights, but DMAS only started collecting RUG IV - 48 information in June 2013. DMAS will need more complete**

RUGs IV - 48 information before it can determine either the normalization to RUG 34 weights or the potential facility impact.

Q20. What case mix scores will be used to calculate the November 1, 2014 rates that will be paid on a claim-by-claim basis?

A20. **For claims with dates of service on or after November 1, 2014, nursing facilities will be required to submit the Resource Utilization Group (RUG) on each claim. DMAS will send out a Medicaid Memo detailing the billing instructions for submitting the RUG. The RUG adjusted direct rate will be added to the sum of the other rate components to produce the total per diem for each claim.**

Q21. What MDS assessment and RUG code should be billed at the start of an admission?

A21. **If the MDS is an admission MDS, it will pay from the day of admission until the next Assessment Reference Date (ARD) date of the scheduled quarterly assessment. However, if there is a significant change after the admission, the new RUG score will be effective as of the ARD date of the significant change assessment.** (***Revised as of 10/27/14***)

Q22. How should the RUG score be submitted on the claim?

A22. **The RUG score should be submitted on the claim with the 0022 revenue code.**

Q23. Since MDS assessments are currently done approximately every 92 days, is that what will be used for billing?

A23. **Yes, however, if there is no significant change in the patient status/condition requiring an updated MDS assessment, the assessment completed at the beginning of the quarter should be used for the whole ARD quarter. The new RUG should be billed until the ARD of the next quarterly assessment. (*Revised as of 10/27/14*)**

Q24. Effective November 1, 2014, how often will the Case Mix Index (CMI) score for each patient need to be updated for billing purposes?

A24. **DMAS plans to require nursing facilities to follow the current MDS process for Medicaid patients. At full implementation of the price-based methodology on November 1, 2014, if there is a significant change in the patient's status, a new RUG code should be reported on the claims on or after that date. We will issue a Medicaid memo detailing the billing instructions prior to full implementation on November 1, 2014.**

Q25. What version of the RUGs Grouper is being used for price-based reimbursement?

A25. **For price-based reimbursement DMAS is using RUG-III – 34 Medicaid grouper, version 5.20. The version will be updated based on revisions implemented by the Centers for Medicare and Medicaid Services for MDS 3.0.**

Q26. How does DMAS define a late assessment?

A26. **If the Omnibus Budget Reconciliation Act (OBRA) assessment does not have an ARD within the timelines as defined by the requirements in the Resident Assessment Instrument (RAI) manual published by CMS, the assessment shall be considered late. The nursing facility shall bill the default RUG code until a new assessment has been completed and accepted.**

Assessments with Assessment Reference Dates (ARD) that do not comply with OBRA scheduling requirements are subject to default. For example, a quarterly assessment is required to have an ARD no more than 92 days after the most recent OBRA assessment's ARD. If the provider does not open this assessment until after the last required date, then the provider will need to bill the default rate from 92 days after the most recent OBRA assessment until the next OBRA assessment's ARD. All OBRA scheduling requirements as listed in the RAI manual apply. (*Revised from 9/26 Medicaid Memo*)

Q27. What types of assessments in A0310 may be used for payment?

A27. **Only the federally required OBRA assessments listed in A0310A will be used for the price-based payment effective November 1, 2014.**

Q28. Where should the assessment date be reported on the claims?

A28. **The nursing facility should report the assessment reference date with the occurrence code 50 for each Health Insurance Prospective Payment System Code (HIPPS) reported on the claim. This billing requirement is similar to Medicare.**

The date of service reported with occurrence code 50 must contain the ARD associated with the applicable OBRA assessment. An occurrence code 50 is not required with the HIPPS code reported for default RUG AAA. (*Revised from 9/26 Medicaid Memo*)

Q29. If a member exhausts Medicare benefits and Medicaid becomes the primary payer, which MDS should be used to bill the initial RUG under Medicaid?

A29. **The nursing facility should bill the Medicaid RUG calculated and in effect on the dates of service billable to Medicaid. All residents admitted to a Medicaid-certified bed must have assessments completed as per the OBRA 1987 requirements. These requirements are detailed in the RAI Manual. Whether a resident is admitted to receive Medicare Part A services, under a Managed Care contract, Medicaid, or paying privately the provider must follow the OBRA assessment requirements if the resident is in a Medicaid-certified bed. When a resident admitted under a different payer converts to Medicaid, the provider will bill using the RUG score from the most recent OBRA assessment. The most recent OBRA assessment may have been combined with an assessment for Medicare Part A. (*Revised as of 10/27/14*)**

Q30. What amount will DMAS pay if the calculated price-based reimbursement is greater than actual charges?

A30. **If the calculated price-based reimbursement exceeds the charges, DMAS will pay the calculated rate. The lesser of billed charges theory will not apply to price-based reimbursement payments.**

Q31. What is the procedure for adjusting claims for RUG billing?

A31. **If a provider completed a MDS assessment and later corrected the assessment, the provider *must* adjust claims to submit the adjusted RUG code. Providers should follow the claim adjustment procedures to change the RUG code billed for dates of service affected by the change. The guidelines for claim adjustments will be documented in the Nursing Facility Manual. (*Revised from WebEx Training Billing Procedures*)**

Q32. If an OBRA is combined with a PPS MDS, will the facility use the A0310A for the assessment type/modifier for billing even though the MDS is combined?

A32. **Only the federally required OBRA assessments listed in A0310A will be used for the price-based payment effective November 1. The assessment type/modifier billed with the RUG should be the values in item A0310A.**

Q33. a.) If a resident discharges from the facility prior to the due date of his quarterly assessment and returns after the quarterly assessment was due, how can the facility prevent receiving the default RUG payment? b.) Since facility's do not bill for days in the facility, would an ARD need to be set upon returning to the facility to prevent default RUG payment or combine the quarterly due with the discharge?

A33. **If a resident has an OBRA assessment due and the resident is out at the hospital, the provider has 14 days after the return (counting the return as day 1) to complete the OBRA assessment.**

From RAI manual: When the resident returns to the nursing home, the IDT must determine if criteria are met for a SCSA (only when the OBRA Admission assessment was completed prior to discharge.

1. **If criteria are met, complete a Significant Change in Status assessment.**
2. **If criteria are not met, continue with the OBRA schedule as established prior to the resident's discharge.**
3. **If a SCSA is not indicated and an OBRA assessment was due while the resident was in the hospital, the facility has 13 days after reentry to complete the assessment (this does not apply to admission assessment).**

Q34. What two digits should be used following the RUG code?

A34. **The RAI manual, chapter 6 instructions are specific to Medicare SNF PPS billing guidelines. The Medicaid Memo and the WebEx training materials describe the Medicaid billing instructions. Please submit the assessment type values noted in item A0310A with the RUG code in the last two digits of the HIPPS rate code locator on the UB-04 form. These values denote if the Medicaid assessment is an admission, quarterly, annual, significant change, etc.**

COST SETTLEMENT AND REPORTING

Q35. How much of the current payment (effective July 1, 2014) will be cost settled?

A35. **Payments for dates of service on or after July 1, 2014 will not be settled. Myers and Stauffer will continue to collect and audit cost reports, but we will not retroactively adjust price-based rates.**

Q36. Will changes be made to the existing PIRS cost report to report Medicaid Coordinated Care days separately and not include in the rate calculation on Schedules H and R-1?

A36. **The CCC days will not be reported separately, the CCC days should be included in the total days reported for the facility. Only Medicaid fee-for-service days should be reported as Title XIX days.**

DMAS is in the process of reviewing the cost report changes. We will provide updated cost report instructions through the cost settlement vendor.

INTERMEDIATE CARE FACILITES (ICFs) OPERATED BY DBHDS

Q37. How will the new price-based reimbursement methodology affect payments to Intermediate Care Facilities (ICFs)?

A37. **There will be no change to the payments of Intermediate Care Facilities (ICFs) operated by the Department of Behavioral Health and Developmental Services (DBHDS).**

HOSPICE REIMBURSEMENT

Q38. How will the price-based methodology impact reimbursement for hospice services when using a nursing facility?

A38. **Hospice providers will be reimbursed 95 percent of the July 1 case-mix adjusted rates effective November 1 for hospice services delivered to nursing facility residents.**

NEW NURSING FACILITIES

Q39. How will the rate for a new nursing facility be established under price-based reimbursement?

A39. **1.) Myers and Stauffer (MSLC) will request that the provider complete the new FRV report to set the FRV rate, 2.) MSLC will request documentation of licensing for NATCEP services and 3.) DMAS will calculate all other rate components (100% of the price-based rate for indirect and direct operating rates, an average NATCEPs rate based on facilities with NATCEPs costs and an average CRC rate to include facilities without zero CRC costs).**

THERAPEUTIC LEAVE/LEAVE OF ABSENCE (LOA)

Q40. *If a resident's ARD becomes due before the resident returns to the facility will the nursing facility have to bill the default RUG code? Could the nursing facility set the ARD early before the resident leaves for therapeutic leave?*

A40. ***For a leave of absence (LOA), the resident remains admitted to the Medicaid bed at the facility. Therefore, the provider will need to make sure that any assessment due during the LOA is completed timely. Setting the ARD early is acceptable. Note that if there is no assessment generating a RUG score when the assessment is due, the default days will apply.***

Q41. How should facilities bill the RUG units for claims with therapeutic leave?

A41. **The RUG units billed must match the covered days on the claim. If a revenue code is billed for accommodation or room and board, the service units billed for the revenue code must equal to the number of days covered by the from-thru dates of service for the payment request.**

GENERAL QUESTIONS

Q42. Will rates be updated annually?

A42. **Rates will be increased annually by inflation forecast by IHS Global Insight unless modified by the General Assembly. DMAS will rebase rates in SFY18 and every three years thereafter using the most recent calendar year settled cost reports for freestanding nursing facilities for the base year.**

Q43. Will there be any additional state funding for Medicaid rates?

A43. **The proposed budget includes full funding for nursing facilities for the first time since FY08. When fully transitioned, however, an additional $10 million in funding is needed for the proposed changes in the operating payments. This additional funding is achieved by reducing the FRV rental rate floor from 9.0% to 8.0% over four years.**

Q44. How can I contact DMAS if I have additional questions regarding changes to the nursing facility payment methodology, including changes to FRV?

A44. **For all questions regarding changes to the nursing facility payment methodology, including FRV, you may contact DMAS at the following address NFPayment@dmas.virginia.gov**